GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
APPLICATION TO DETERMINE ELIGIBILITY

Refer to the Instructions When Filling in this Application

Please provide all the information requested and return this form to the GHPP.
PLEASE TYPE OR PRINT. DO NOT ABBREVIATE.

If you have any questions about completing this form,
call the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597.

Section A: Personal Information

1. Name (Last) (First) (MI)	2. Other Name(s) Used	3. Social Security Number (Optional)	
4. Address (Number, Street, Apartment Number)	City	County	Zip Code
4(a). Mailing Address (if different from above)	City	County	Zip Code

5. Day Telephone Number ( )	6. Evening Telephone Number ( )	7. Mother's First and Last (Maiden) Name	8. Primary Language
9. Date of Birth (mm/dd/yyyy)	10. Place of Birth County: State: Country:		11. Gender ☐ Male ☐ Female
12. What is Your GHPP Eligible Condition?			
13. Race/Ethnicity			

14. Name of Your Physician	15. Physician's Phone Number
14(a) Physician's Address	( )

16. Power of Attorney/Conservator Information (If Applicable)

YOU MUST ATTACH SUPPORTING DOCUMENTATION

Name:_____ Title:_____

Address:_____ Telephone Number: ( ) _____

Section B: Health Insurance Information

17. Do You Have Medi-Cal? Yes ____ No ____
a. If Yes, What is Your Beneficiary I.D. Card (BIC) Number? _____

18. Do You Have Medicare? Yes ____ No ____ a. If Yes, What is Your Medicare Number? _____

b. Please Check All Medicare Programs in which You are Enrolled: Part A ☐ Part B ☐ Part C ☐ Part D ☐

Section B: Health Insurance Information (continued)

19. Do You Have Other Health Insurance? Yes ____ No ____ a. If Yes, Name of Plan:_____

b. Type of plan: Preferred Provider (PPO)_____ Health Maintenance Organization (HMO)_____ Other (Specify)_____

c. Policy Number_____ Coverage Start Date:_____

d. Who Pays for the Policy? Employer_____ Self_____ Other (Specify) _____

20. Do You Have: a. Dental Insurance? Yes ____ No ____ If Yes, Name of Plan:_____

b. Vision Insurance? Yes ____ No ____ If Yes, Name of Plan:_____

Section C: Certification

(Initial and Sign Below. Your Signature Authorizes the GHPP to Proceed with Your Application.)

Read and Initial Each Statement Below:

_____ I am applying to the GHPP in order to determine my eligibility for services/benefits. I understand that the completion of this application does not guarantee my acceptance into the GHPP.

_____ I give my permission for the GHPP to verify my residence, health information, income and/or other circumstances which may be required to determine my GHPP eligibility and enrollment fee amount (if any).

_____ I give permission for the GHPP to leave messages concerning my GHPP participation on my designated telephone answering machine/service.

_____ I certify that I have read this information, or had it read to me, and that I understand it.

_____ I certify that the information I have given on this form is true and correct to the best of my knowledge.

Signature of GHPP Applicant or Parent/Legal Guardian of Minor Child:	Relationship to Minor Child:	Date:
_____	_____	_____

If Signing with an "X", Signature of Witness:	Relationship of Witness to GHPP Applicant:	Witness Phone Number:	Date:
_____	_____	( )	_____

California law requires that families applying for services be given information on how GHPP protects their privacy.[1]
To protect your privacy:

- GHPP must keep this information confidential.[2]
- GHPP may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and GHPP records concerning you. If you wish to see these records contact the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.[3]

1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)
3 Section 123800 et. seq. of the California Health and Safety Code

INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) APPLICATION
TO DETERMINE ELIGIBILTY

Please print clearly so your application can be processed as quickly as possible.

Fill out each section completely. If you do not provide all the information requested, the GHPP will be unable to proceed with your application. If you need help in filling out this form, please contact the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597. Once the application is completed, mail it to the GHPP. **PLEASE REMEMBER TO SIGN AND DATE THE FORM.**

Section A: Personal Information: This includes identifying information and other information necessary to process this form.

1. **Name**: Write your last name, first name, and middle initial. **Attach proof of identity, such as a copy of your California driver's license or California identification card.**

2. **Other name(s) used:** If you are legally known by any other name, write in the name.

3. **Social Security Number (OPTIONAL):** Write your nine-digit Social Security Number.

4. **Address:** Write your residence street number, street name, apartment number, city, county, and zip code. Do not use a P.O. Box in this space. **Attach a copy of one of the following to show proof of residency in California.** If you do not have one of the following items, please call the GHPP to discuss additional acceptable items.

• Current California utility bill • Rent or mortgage receipt • Document showing employment in California	• Evidence of registering to vote in California • Evidence of enrollment in a California school • Evidence of receiving California public assistance

4a. **Mailing address:** Write your mailing address. If you prefer to receive your mail at a P.O. Box, write in this space.

5. **Day telephone number:** Write the telephone number where you can be reached during the day including area code.

6. **Evening telephone number:** Write the telephone number where you can be reached in the evening including area code.

7. **Mother's first and last (maiden) name:** Write your mother's first name and last (maiden) name.

8. **Primary language:** Write the name of the language in which you are most comfortable communicating.

9. **Date of birth:** Write the month, day, and year of your birth.

10. **Place of birth:** Write the county and state in which you were born. Write the country if you were born outside of the United States.

11. **Gender:** Please check the correct gender (male or female).

12. **What is your GHPP eligible condition?** Write the condition which qualifies you for the GHPP. The following is a list of GHPP-eligible conditions:

• Cystic Fibrosis • Friedreich's Ataxia • Hemophilla Factor Deficiency (please specify factor type) • Huntington's Disease • Joseph's Disease • Sickle Cell Disease • Thalassemia Major • Thrombasthenia	• Thrombocytopathia • Von Hippel-Lindau • Von Willebrand's Disease • Metabolic Disease (e.g., PKU, Tyrosinemia, branch chain amino acid, Maple Syrup Urine Disease, urea cycle disorders, Wilson's Disease) • Other metabolic disease (please specify)

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13. Race/ethnicity: Write the category from the following list which best describes your primary race/ethnicity.

• Alaskan Native • Amerasian • American Indian • Asian • Asian Indian • Black/African-American • Cambodian • Chinese • Filipino • Guamanian	• Hawaiian • Hispanic/Latino • Japanese • Korean • Laotian • Samoan • Vietnamese • White • Other

14. Name of your physician: Write the name of your primary physician.

14a. Physician's address: Write your physician's street number, street name, city, county, and zip code.

15. Physician's telephone number: Write the primary physician's telephone number including the area code.

16. **Power of Attorney/Conservator information:** If you have legally appointed someone to act as your Power of Attorney for health care, or if a conservator has been appointed for you please write the name, title (i.e. Power of Attorney, Conservator), address, and telephone number for this individual. **You MUST attach documentation of this person's legal authority to act on your behalf if you wish for them to be able to communicate with the GHPP regarding your health care.**

Section B: Health Insurance Information: The GHPP is considered the payer of last resort. In other words, the GHPP will pay for your medically necessary health care only after any other health coverage you may have has paid.

17. Do you have Medi-Cal? Check the correct response (Yes or No).
- **a. If yes, what is your Beneficiary I.D. Card (BIC) number?** Write your BIC I.D. number.

18. Do you have Medicare? Check the correct response (Yes or No).
- **a. If yes, what is your Medicare number?** Write your Medicare I.D.
- **b. Please check all Medicare programs in which you are enrolled:** Check all that apply (Parts A, B, C, D).

19. Do you have other health insurance? Check the correct response (Yes or No).
- **a. If yes, name of plan:** Write the full name of your health plan (i.e. Kaiser Permanente, Blue Cross of California, etc.).
- **b. Type of plan:** Check the response which matches the type of plan you have.
  NOTE: If you have an HMO or PPO, please send a copy of your benefit booklet with your GHPP application.
- **c. Policy number/Coverage start date:** Write your health insurance policy number and the start date of your coverage.
- **d. Who pays for the policy?** Please check the response which applies to your policy. If you check "Other" please specify who pays (i.e. Family).

20. Do you have
- **a. Dental Insurance?** Check the correct response (Yes or No). If Yes, write the name of the plan.
- **b. Vision insurance?** Check correct response (Yes or No). If Yes, write the name of the plan.

Section C: Certification: Read and initial the statements where indicated on the form. Then sign and date in ink, in the spaces provided. If you sign your name with an "X," you must have a witness sign in the space indicated.

Submitting your application: Mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413.